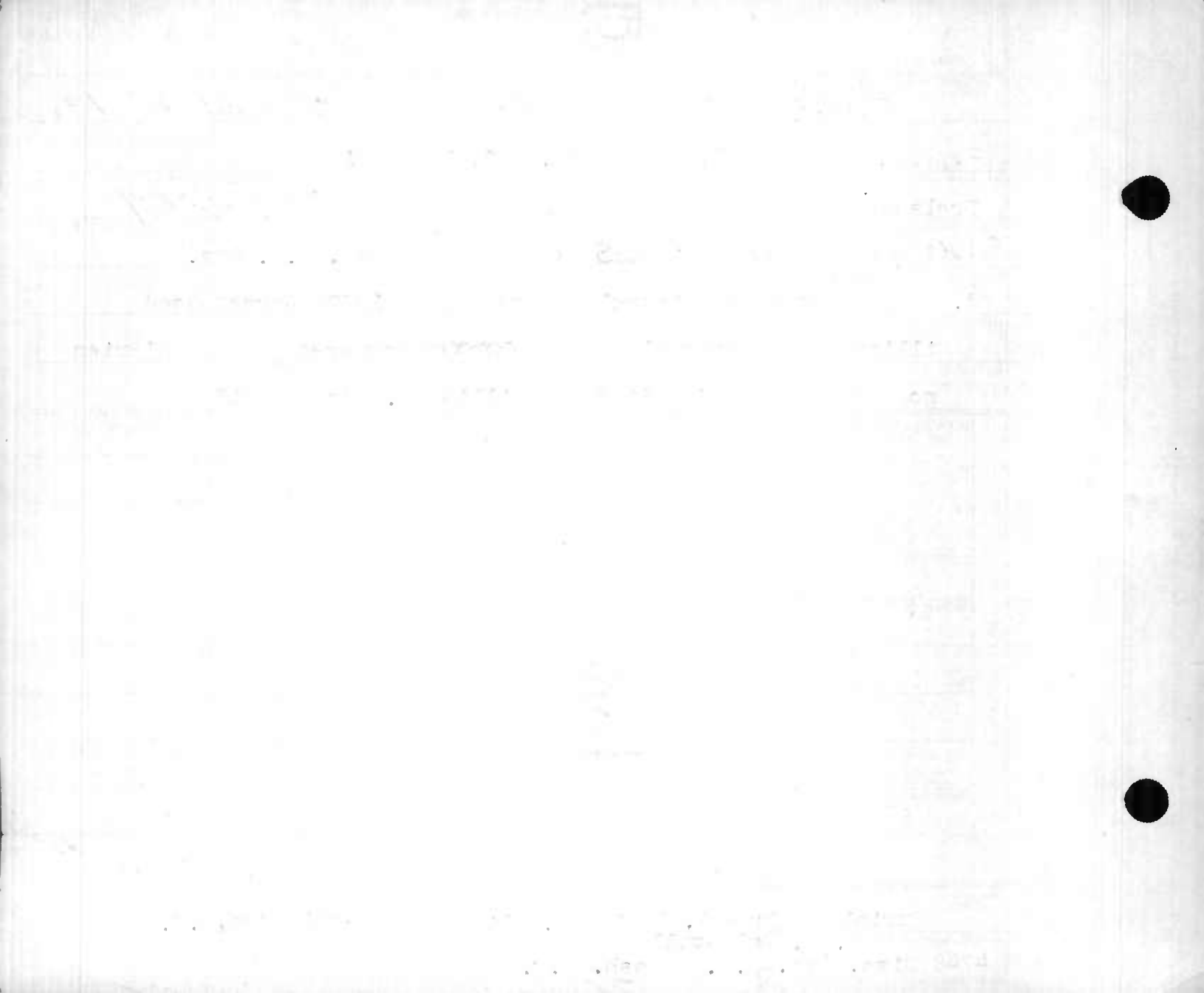


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 6 0 1 8			
1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ANNA M. UTZ				2a. DATE OF DEATH MONTH DAY YEAR 5 - 31 - 80		2b. HOUR 1:16 A.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. U.S. Gov.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William McDonald		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret O'Brien		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578 30 3902	
17. INFORMANT William J. Utz		17. ADDRESS #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART 1 DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Cardiopulmonary failure				1 day			
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia & septicaemia (pseudomonas)				5 days			
DUE TO, OR AS A CONSEQUENCE OF (c) Perforated, bleeding duodenum w/ ulcer				9 days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal Failure							
19a. DATE OF OPERATION 5/21/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated bleeding ulcer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/21/80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		21g. CITY OR TOWN		21h. COUNTY	
21i. STATE		21j. DATE OF INJURY		21k. TIME OF INJURY		21l. PLACE OF INJURY	
22a. I certify that (1) (this hospital) attended the deceased from 5/21/80 to 5/31/80 , that (1) (we) last saw the deceased alive on 5/30 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Martin Eichner		22c. DEGREE MD.		22d. ADDRESS 3915 Ferrara Dr S.W. 20906		22e. DATE SIGNED 5/31/80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 3, 1980		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION CITY OR TOWN Washington, D.C.	
23e. COUNTY		23f. STATE		24. FUNERAL DIRECTOR W. W. Taltavull		25. DATE RECEIVED BY REGISTRAR JUN 3 1980	
24. ADDRESS 4748 Wisc. Ave. N.W. Wash. D.C.		25. REGISTRAR'S SIGNATURE [Signature]					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The physician certifies that the death of the decedent was caused by the terminal disease or condition stated on this certificate, and that the decedent was not injured, or otherwise traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8016019			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) ^{FIRST} JANE ^{MIDDLE} P. ^{LAST} VALLI				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
				6 10 1980		2:51 PM	
3 SEX MALE female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS.	
				5 MONTH 6 DAY 05 YEAR		75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Wash. D.C.		USA				Montgomery County MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring Md		Holy Cross Hospital Silver Spr Md		Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Mont.		S.S.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME ^{FIRST} Richard ^{MIDDLE} Poggoli ^{LAST}		15 MOTHER'S MAIDEN NAME ^{FIRST} Mary ^{MIDDLE} Sbalbi ^{LAST}		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
				None			
16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
085 16 8262		Peter C. Valli (Husband)		Same as above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4292 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular fibrillation</u>							10 min.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular d.</u>							year.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>May 14</u> 19 <u>80</u> to <u>June 10</u> 19 <u>80</u> , that (1) (we) lost saw the deceased alive on <u>May 14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James R. Coleman</u>				DEGREE		22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6-10-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES R. COLEMAN</u>				22e. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING MARYLAND 20910</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		6/13/80		Mount Oliver Cemetery		Washington D.C.	
24 FUNERAL DIRECTOR NAME <u>Hines/Rinaldi</u> ADDRESS <u>F.H.11800 N.H.Ave.S.S.Md.</u>				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				JUN 16 1980			

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Items 12a & b, G547 9/3/80 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 80 16020

FOR STATE REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Edith Louise Vaughn			2a DATE OF DEATH MONTH DAY YEAR June 4, 1980		2b HOUR 3:50 AM
3 SEX Female	4 RACE Negro	5 DATE OF BIRTH MONTH DAY YEAR June 22, 1925	6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS	7 IF UNDER 1 YEAR MONTHS DAYS 8 IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Beth. Md		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Pennsylvania		13c CITY OR TOWN Philadelphia	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 5738 Arch Street	
14 FATHER'S NAME FIRST MIDDLE LAST James W. Vaughn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith M. Stubbs			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 609-20-4613	17 INFORMANT ADDRESS Mrs. Edith M. Vaughn (mother) Add. Same			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Severe Syngene → Respiratory + Cardiac Arrest</u> 4251 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Idiopathic Hypertrophic Subaortic Stenosis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sp Left Ventricular Aneurysm + Myotomy</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)					
19a DATE OF OPERATION 5/29/80		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Congenital heart disease		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (this hospital) attended the deceased from <u>May 25</u> , 19 <u>80</u> , to <u>June 4</u> , 19 <u>80</u> , that <u>we</u> lost saw the deceased alive on <u>June 4</u> , 19 <u>80</u> , and that in <u>our</u> opinion death occurred on the date and hour and from the causes stated above, <u>we</u> (did) <u>not</u> view the body after death.					
22b SIGNATURE <u>Joseph B. Zwischenberger MD</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 6/4/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. B. Zwischenberger MD				22e ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 6-10-80		23c NAME OF CEMETERY OR CREMATORY Glenwood Memorial	
23d LOCATION CITY OR TOWN Broomall		23e COUNTY PA.		23f STATE PA.	
24 FUNERAL DIRECTOR NAME JONES + JONES F.H.				25a DATE REC'D. BY REGISTRAR JUN 5 1980	
25b REGISTRAR'S SIGNATURE <u>Ruby Reddy</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

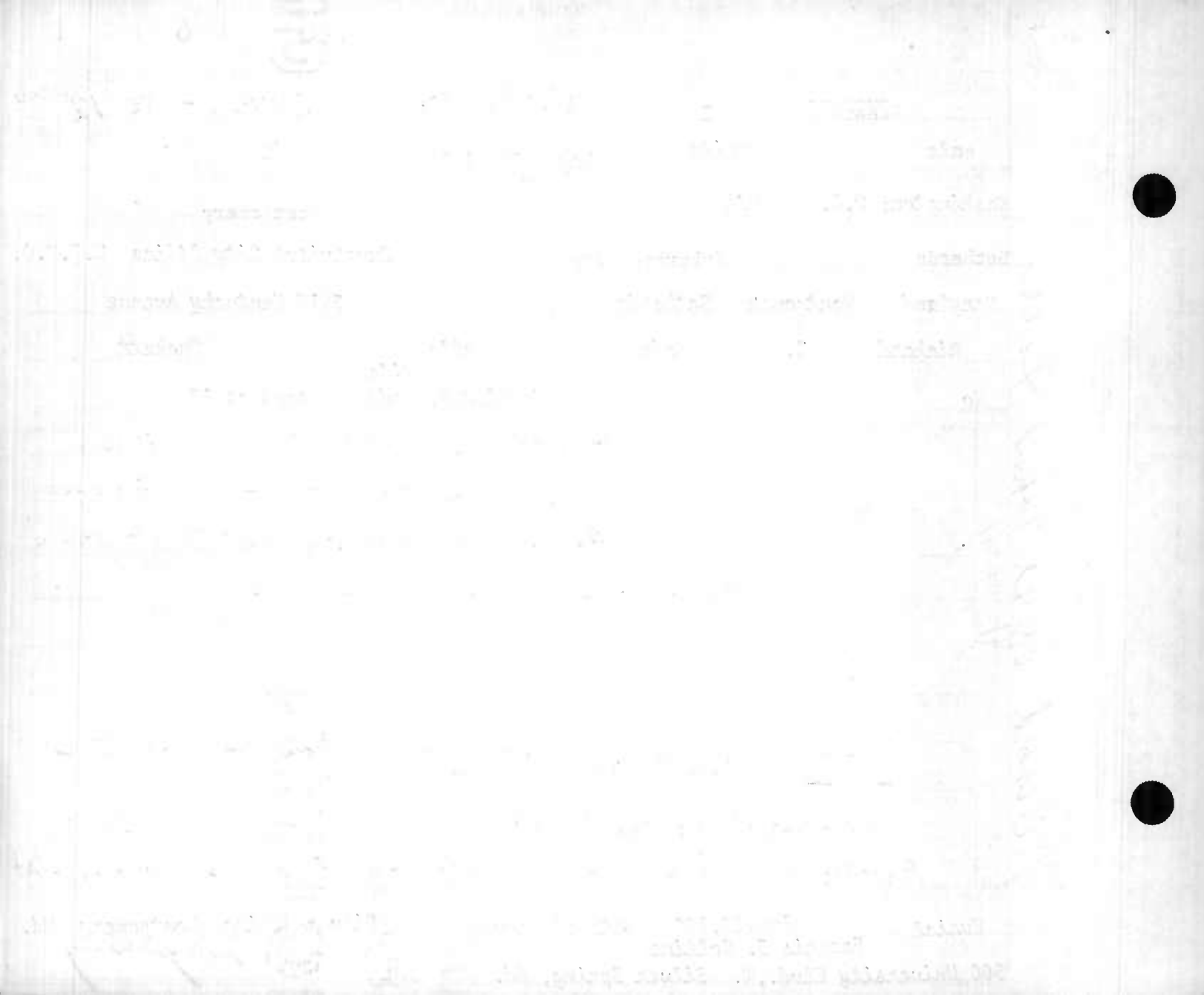
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be checked for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (Mandatory) If item 21 is marked as item 18, then any injury or other traumatic event, or any condition which may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 6 0 2 1										
1. FOR STATE REGISTRAR										REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR		
BERNARD			T				WADE, Sr.		JUNE			24		80		12		noon		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR			8 IF UNDER 24 HRS					
male			white			May 13 1910			70			YRS.			MONTHS			DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH											
Washington, D.C.			USA						Montgomery Md.											
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda			Suburban Hosp			Supervisor City Office			U.S.P.O.											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Maryland			Montgomery			Bethesda			YES <input type="checkbox"/> NO <input type="checkbox"/>			7915 Kentucky Avenue								
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME																	
Richard I. Wade			Della Duckett																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS											
No						Harriet R. Wade			same as 13											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>										10 weeks										
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF				2 years						
										DUE TO, OR AS A CONSEQUENCE OF				14 years						
										DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																				
Metastatic Prostatic Carcinoma																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)														
			P.M. 19																	
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN			COUNTY								
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET						STATE								
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>June 19 60</u> to <u>June 24 80</u> , that (I) <u>lost</u> saw the deceased alive on <u>June 21 80</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.																				
22b. SIGNATURE										DEGREE			22c. DATE SIGNED							
FRANK Y. JAGGERS JR.										MD			6/24/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS										
5000										6000 Executive Bld Rockville Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			CITY OR TOWN								
Burial			Jun. 27, 1980			Gate of Heaven			Silver Spring			Montgomery Md.								
24 FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Francis J. Collins			500 University Blvd., W. Silver Spring, Md.			JUL 1 1980			Ruthy McCreedy											



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 6 0 2 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Freeda W. Wallace			2a. DATE OF DEATH MONTH DAY YEAR June 10, 1980			2b. HOUR 8:30^P				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-19-1931		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Mail Clerk		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4405 - Briggs Chaney Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence E. Wilson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha E. Hovermale							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 233-48-7038		17. INFORMANT ADDRESS Same as Darlene L. Wallace (Dtr.) above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 2503 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Anemia (c) Diabetic Mellitus								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes 3 years? 14 years plus		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Anemia Congestive Heart Failure Renal insufficiency Generalized Arteriosclerosis										
19a. DATE OF OPERATION 5-21-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gortex Graft for Hemodialysis				20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from June 10, 1980 , to June 10, 1980 , that (I) (we) last saw the deceased alive on June 10, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Alan R. Gair MD		DEGREE MD				22c. DATE SIGNED 6-10-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN R. GAIR MD		22e. ADDRESS 11700 Old Columbia Pike Silver Spring, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-13-80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.				
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.		ADDRESS Mt. Rainier, Md.		25. DATE RECEIVED BY REGISTRAR JUN 18 1980						

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Henry			MIDDLE Vincent			LAST Walsh			2a. DATE KNOWN OF DEATH ESTIMATED			<input checked="" type="checkbox"/> MONTH DAY YEAR 6/12 1980			2b. HOUR 11:40 A.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG 26, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD June 12 1980			2d. HOUR 11:40 A.M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.								
10. CITY OR TOWN OF DEATH Bethesda, Md.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIREMAN				12b. KIND OF BUSINESS OR INDUSTRY D.C. GOVT.						
13a. STATE				13b. COUNTY		13c. CITY OR TOWN WASHINGTON, D.C.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 225 ROCK CREEK CHURCH RD., N.W.								
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS E. WALSH						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOLLIE GRINDER														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-10-2106		17. INFORMANT CATHERINE WALSH				ADDRESS SAME AS 13 WIFE										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Carcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																				
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																				
ACTUAL SIGNATURE <u>John G. Ball</u>				TITLE (SPECIFY) M.D. <u>Deputy</u>				MEDICAL EXAMINER				DATE SIGNED June 12, 1980								
EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL				ADDRESS BETHESDA, MARYLAND																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6/16/80		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY				23d. LOCATION WASHINGTON, D. C. COUNTY STATE										
24. FUNERAL DIRECTOR 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										25a. DATE REC'D. BY REGISTRAR JUN 13 1980		25b. REGISTRAR'S SIGNATURE <u>Robert M. Cuddy</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. After death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 6 0 2 4	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MOLLIE S. WALSH				2a. DATE OF DEATH MONTH 6 DAY 13 YEAR 80				2b. HOUR 11 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH MAY DAY 1 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		7. IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10. CITY OR TOWN OF DEATH CHEVY CHASE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BETHESDA RETIREMENT & NURSING CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 71505 LOCKHART PLACE			
14. FATHER'S NAME FIRST MORRIS MIDDLE SNYDER LAST SNYDER				15. MOTHER'S MAIDEN NAME FIRST FAY MIDDLE ALBERT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 185-09-9037A		17. INFORMANT ADDRESS CAPT. JAMES J. WALSH, same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac respiratory arrest 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) metastatic Carcinoma of Breast (c) Carcinoma of Right Breast										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 1975 1975	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that W.H. Killay (this hospital) attended the deceased from June 4 , 19 80 , to June 13 , 19 80 , that if (we) (I) (we) (I) saw the deceased alive on above, (I) (we) (I) (we) (I) (we) view the body after death.											
22b. SIGNATURE W.H. Killay MD for J.B. Fitzgerald MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED June 14 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.H. Killay MD for J.B. Fitzgerald MD				22e. ADDRESS 2215 Wisconsin A Bethesda Md 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/17/1980		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY				23d. LOCATION CITY OR TOWN COUNTY ARLINGTON, VIRGINIA			
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR JUN 10 1980				25b. REGISTRAR'S SIGNATURE Robert K. ...			
24. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.											

6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

DECEASED

WIFE OF MRS. JAMES J. WALSH, JR. (NEE ALBERT)
BORN 6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

WIFE OF MRS. JAMES J. WALSH, JR. (NEE ALBERT)
BORN 6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

WIFE OF MRS. JAMES J. WALSH, JR. (NEE ALBERT)
BORN 6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

WIFE OF MRS. JAMES J. WALSH, JR. (NEE ALBERT)
BORN 6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

WIFE OF MRS. JAMES J. WALSH, JR. (NEE ALBERT)
BORN 6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

WIFE OF MRS. JAMES J. WALSH, JR. (NEE ALBERT)
BORN 6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

WIFE OF MRS. JAMES J. WALSH, JR. (NEE ALBERT)
BORN 6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

WIFE OF MRS. JAMES J. WALSH, JR. (NEE ALBERT)
BORN 6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

WIFE OF MRS. JAMES J. WALSH, JR. (NEE ALBERT)
BORN 6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

WIFE OF MRS. JAMES J. WALSH, JR. (NEE ALBERT)
BORN 6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

WIFE OF MRS. JAMES J. WALSH, JR. (NEE ALBERT)
BORN 6/17/1900 ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO. 8016025										
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2. DATE OF DEATH			MONTH	DAY	YEAR	2. HOUR	
Fred D. Walter Sr.						6 7 80						95' M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
Male			White			9 9 12			67 YRS.			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIAGE STATUS			9. BALTIMORE CITY OR COUNTY OF DEATH				
MD			USA			NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery MD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										
Rockville			Shady Grove Seventh Day Adventist										
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Retired													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS	
MD			Montgomery			Gaithe			YES <input type="checkbox"/> NO <input type="checkbox"/>			19701 Laytonsville Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
Whitney			Walter.			Beatrice			Weaver.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS				
NO			578073321			J. Lawless RN			3614 4W				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 1541 CARCINOMATOSIS										3 DAYS			
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF RECTUM										MONTHS			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
EMPHYSEMA -													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
6-1-80			BOWEL OBSTRUCTION			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
			HOUR A.M. MONTH DAY YEAR										
			P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			CITY OR TOWN COUNTY STATE				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			STREET							
22a. I certify that (I) (this hospital) attended the deceased from 5-30 1980, to 6-7 1980, that (I) (we) last saw the deceased alive on 6-7 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						DEGREE			22c. DATE SIGNED				
IRA MILLER						MD			6/8/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
IRA MILLER						8218 Wisconsin Ave. Bethesda MD							
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION				
Burial.			June 11, 1980			George Washington Riggs Rd. P. G. Co.			Maryland				
24. FUNERAL DIRECTOR			25a. CARROLL ST. N. W. D. C.			25b. DATE REC'D. BY REGISTRAR			25c. REGISTRAR'S SIGNATURE				
Takoma Funeral Home			JUN 12 1980										

✓

Witchney Major Captain Major

June 11, 1980 George Washington State P. O. Co.
251 Carroll St. N. E. C. JUN 12 1980
Alton Federal Court



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 16026

1- STATE REGISTRAR		FOR		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		HOUR		MINUTE	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		HOUR		MINUTE	
Jere Frederick Wang		Jere		Frederick		Wang		June 16, 1980		June		16		1980					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		HOUR		MINUTE			
M	W	June 13, 1954	26 YRS.			June 16, 1980		June		16		1980							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Illinois		U.S.A.										Montgomery, Md.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Silk Spg.		8514 Greenward Ave.		Restaurant Employee - Restaurant															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET ADDRESS											
Md		Mont.		Silk Spg.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8514 Greenward Ave.											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
Thomas C. Wang		Mae Hodge		No		261-07-4126		Thomas Wang, Jr. - New Port Richey, Fla.		1800 41st. Terr.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
9554		Shot self		Shot self															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		None																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
None																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
9554		6:14 P.M.		Shot self															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION															
		Home		Greenward Ave. Silk Spg. Mont. Md.															
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
John S. Rogers				M.D.		June 16, 1980													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		1919 Seminary Rd., Silver Spring, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE									
Cremation		June 19, '80		Ft. Lincoln Crematory		Brentwood		P.G.		Md.									
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Hines/Rinaldi		Funeral Home		11800 N.H. Ave. Silver Spring, Md.		JUN 23 1980		[Signature]											

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8016027	
1- STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Erieian Wardlow					2a. DATE OF DEATH MONTH DAY YEAR 6-7-80				2b. HOUR 1:37 P.M.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 16, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 1 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Program Analyst		13. KIND OF BUSINESS OR INDUSTRY Bureau of Drugs (Fed.)			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Derwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 17501 Wheat Fall Drive			
14. FATHER'S NAME FIRST MIDDLE LAST Marshall - Wardlow					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elva - Wardlow						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO 151-154 268-26-7278		17. INFORMANT 11259 Brownstown Arnheim Road, Anna L. Schmidt Georgetown, Ohio 45121					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE TESTIS 1521 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-7-80 to 6-7-80 , that (I) (we) last saw the deceased alive on 6-7-80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard H. Pollen						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-7-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD H. POLLEN MD						22e. ADDRESS 10400 CORNELIUS AVE, KENSINGTON, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/11/80		23c. NAME OF CEMETERY OR CREMATORY Dayton Military Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Dayton Montgomery Ohio			
24. FUNERAL DIRECTOR NAME Gartner-Sandison				316 E. Diamond Avenue, Gaithersburg, Md. 20878		25. DATE REC'D. BY REGISTRAR JUN 11 1980					

(M)

Division

Section

Date

Mount

Station

Notes

Remarks

Remarks

Remarks

Remarks

Remarks

X

1-2-3

Remarks

Remarks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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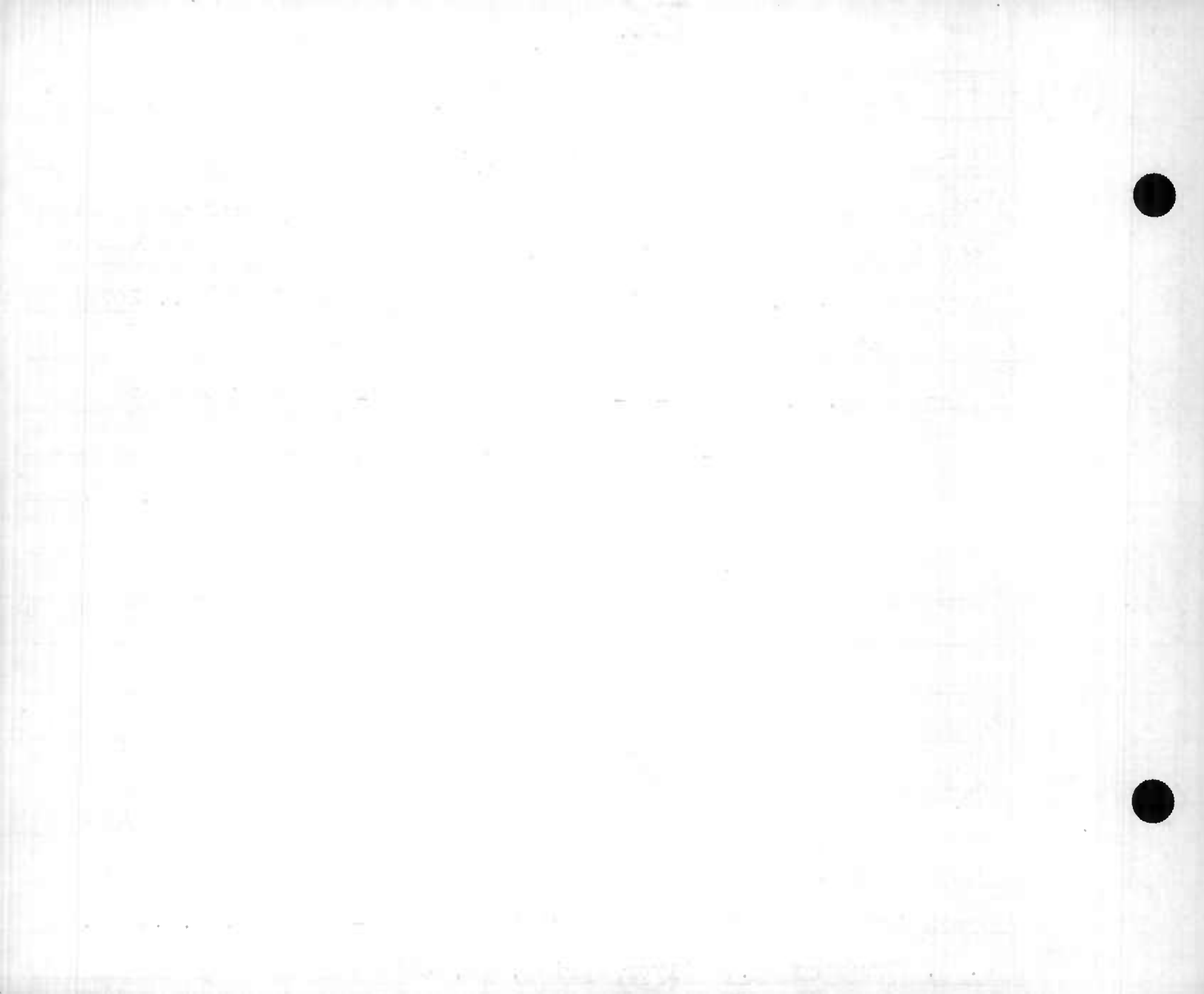
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO. 8016028				
1. DECEASED NAME (TYPE OR PRINT) Stanley Warkoski					2a. DATE OF DEATH MONTH DAY YEAR June 10, 1980				
3 SEX Male					2b. HOUR 5:45 A.M.				
4 RACE Cauc					5. DATE OF BIRTH MONTH DAY YEAR May 2, 1894				
6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS					7. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland					7b. CITIZEN OF WHAT COUNTRY? U.S.A.				
8. CITY OR TOWN OF DEATH Rockville					9. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center				
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Mont. 13c. CITY OR TOWN Rockville					11. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
12. STREET ADDRESS 622 Warfield Dr., 20760					13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber				
14. FATHER'S NAME FIRST MIDDLE LAST Not known					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not known				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. W. W. #1 098-18-8453				
17. INFORMANT ADDRESS Ted Warchall-Same as items #13					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular arrhythmia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4919					DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia				
					DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bronchitis				
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR April 10, 1980				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from April 10, 1980 to June 10, 1980 , that (1) (we) lost saw the deceased alive on June 6, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James R. Moore Jr.					22c. DATE SIGNED 6-10-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Moore Jr.					22e. ADDRESS 207 Brookes Ave Gaithersburg Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation					23b. DATE 6/11/80				
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory-Suitland, P.G., Md.					23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME W. W. Chambers Co., Silver Spring, Md.					25a. DATE REC'D. BY REGISTRAR JUN 12 1980				
25b. REGISTRAR'S SIGNATURE [Signature]									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8016029	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GARRITT D WATERS JR.				2a. DATE OF DEATH MONTH DAY YEAR 6/23/80			2b. HOUR 0212A M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10 03 67			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington,		7b. CITIZEN OF WHAT COUNTRY? D. C. U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.				
10. CITY OR TOWN OF DEATH Rockville MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired News paper.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10120 LITTLE Pond Pkwy			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Waters.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sue. Unknown.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 578-09-9764		17. INFORMANT ADDRESS Mrs. Leary L. Waters. (13 e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> 410 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>acute antero-septal myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 7 hrs 10 years	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>Dec 1979</u> to <u>June 23, 1980</u> , that (1) (we) lost the deceased alive on <u>June 23, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Michael A. Greene MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-23-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Greene, MD				22e. ADDRESS 19271 Montgomery Village Ave Gaithersburg Md. 20860							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation.		23b. DATE June 23, 1980		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln				23d. LOCATION Bladensburg Rd. P. Geo. Md.			
24. FUNERAL DIRECTOR <u>Takoma Funeral Home</u>				25a. DATE REC'D. BY REGISTRAR JUN 26 1980				25b. REGISTRAR'S SIGNATURE <u>John A. Kennedy</u>			

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Washington, D. C. U. S. A.

Continued.

United States Navy.

Unknown.

Unknown.

Robert Watson.

272-10-0700 Mrs. Jenny L. Watson. (11 e)

Continuation. June 22, 1980 Ft. Lincoln. 254 Carroll St. W. D. C. 20540. Oklahoma Turnpike Corp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, prior to burial, cremation, or removal.

IMPORTANT: Pages 21 included on form for those attending the funeral. The attending physician must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8016030			
1. FOR STATE REGISTRAR					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) BELLA			FIRST MIDDLE LAST WEINER		2a. DATE OF DEATH MONTH DAY YEAR 6 12 80			2b. HOUR 3:07 P.M.
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 1st, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY LIQUOR	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA CHELEMSKY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-48-9249		17. INFORMANT ADDRESS MRS. ELEANOR HERSH, 3906 WOODLAWN ROAD, CHEVY CHASE, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Schistosomiasis Chronic (c) Schistosomiasis Chronic DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Dehydration								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1971 to 6-12-80 , 19 80 , that (I) (we) last saw the deceased at 6-5-80 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.								
22b. SIGNATURE Stanley M. Silverberg				DEGREE		22c. DATE SIGNED 6/12/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY M. SILVERBERG				22e. ADDRESS 5530 WISCONSIN AVE. CHEVY CHASE, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/13/1980		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ADELPHI PR. GEORGES MD.		
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				25. DATE RECEIVED BY REGISTRAR JUN 17 1980				
26. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.				27. REGISTRAR'S SIGNATURE				

6 13 80 3019

DEPT. F. 1919

WHITE

FRANCE

MONTGOMERY

U.S.A.

RESIDENCE

LONDON

MONTGOMERY

SILVER SPRING

1110 EAST WEST HIGHWAY

SILVER SPRING

MONTGOMERY

PHILADELPHIA

DEPT. F.

STEINBERG

JOSEPH

302 MONTGOMERY ROAD

577-11-0111

*But the wonderful children
are the children of the world*

Respectfully

+

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1911 6-12

6/15/80

STANLEY M. STEINBERG 2200 Wisconsin Avenue NW

6/12/1980 MOUNT LEBANON CEMETERY, ASHLAND, OHIO

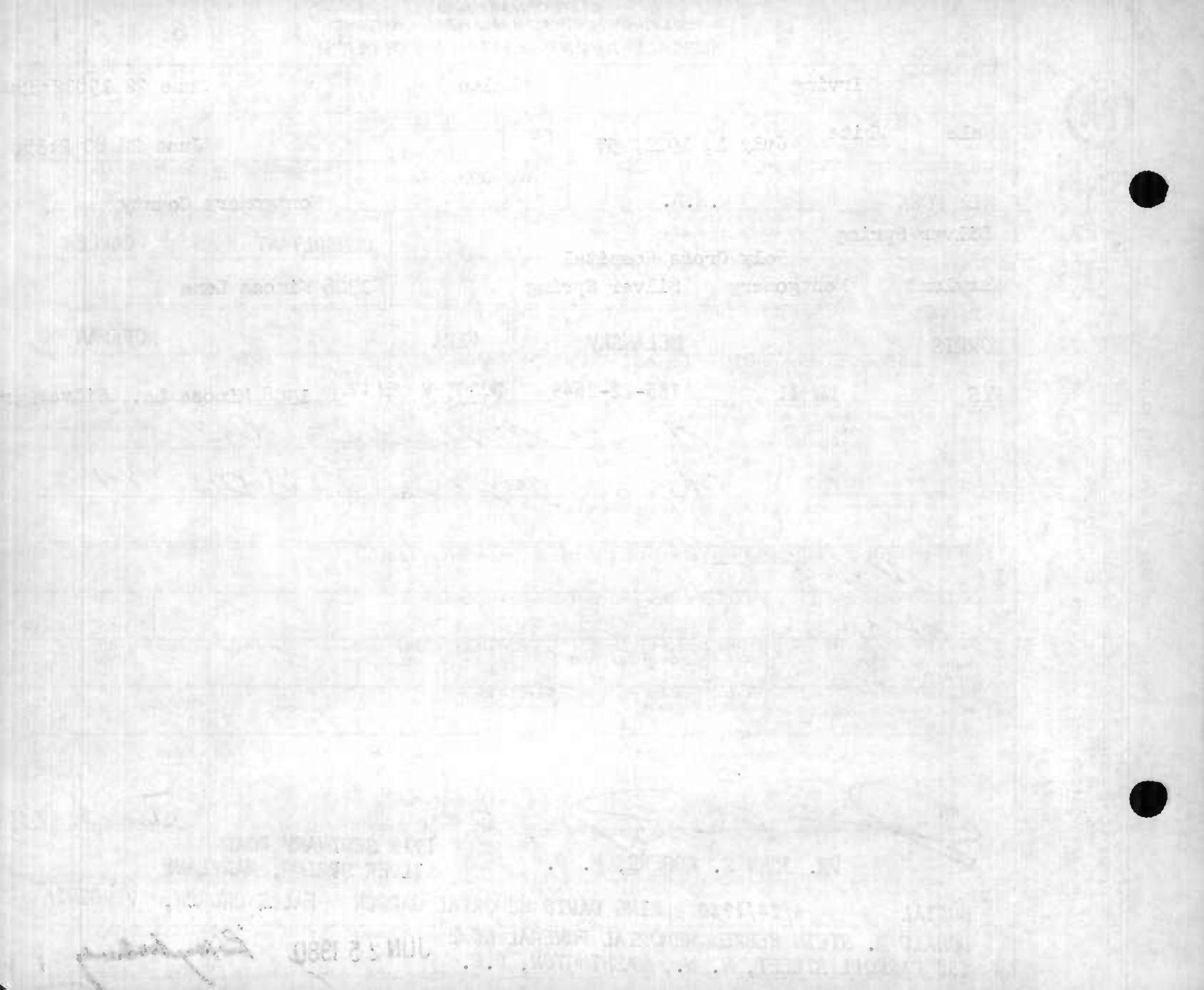
2200 LEBANON STREET, N.W. WASHINGTON, D.C.

Handwritten note on the right margin, possibly a signature or address.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST SIGN AND DATE THE BOTTOM OF THIS CERTIFICATE. **PAGE 1** OF THIS CERTIFICATE IS TO BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. **PAGE 2** OF THIS CERTIFICATE IS TO BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. **PAGE 3** OF THIS CERTIFICATE IS TO BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M7/76

STATE OF MARYLAND										6031	
DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Irving Welan										2a. DATE KNOWN OF DEATH 22 June 1980 2:35 PM	
3. SEX Male 4. RACE White 5. DATE OF BIRTH July 1, 1922 6. AGE (IN YEARS) 57 7. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED [X] NEVER MARRIED [] WIDOWED [] DIVORCED [] 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.										2b. DATE PRONOUNCED DEAD June 22, 1980 2:35 PM	
10. CITY OR TOWN OF DEATH Silver Spring 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSULTANT 12b. KIND OF BUSINESS OR INDUSTRY CAREER											
13. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring 13d. INSIDE CITY LIMITS? YES [X] NO [] 13e. STREET ADDRESS 1308 Mimosa Lane											
14. FATHER'S NAME (FIRST MIDDLE LAST) MORRIS WELANSKY 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) VERA HOFFMAN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES WW II 16b. SOCIAL SECURITY NO. 123-22-2549 17. INFORMANT DOROTHY WELAN ADDRESS 1308 Mimosa La., Silver Spring											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. vs. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None											
19a. DATE OF OPERATION None 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES [] NO [X]											
21a. EXTERNAL CAUSE WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 21d. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy [] Inspection [X] Inquiry [] and in my opinion death resulted from Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner []											
23a. BURIAL, CREMATION, REMOVAL (S'CEBY) BURIAL 23b. DATE 6/24/1980 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN 23d. LOCATION FALLS CHURCH, VIRGINIA											
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D.C. 25. DATE REC'D. BY REGISTRAR JUN 25 1980 26. REGISTRAR'S SIGNATURE [Signature]											



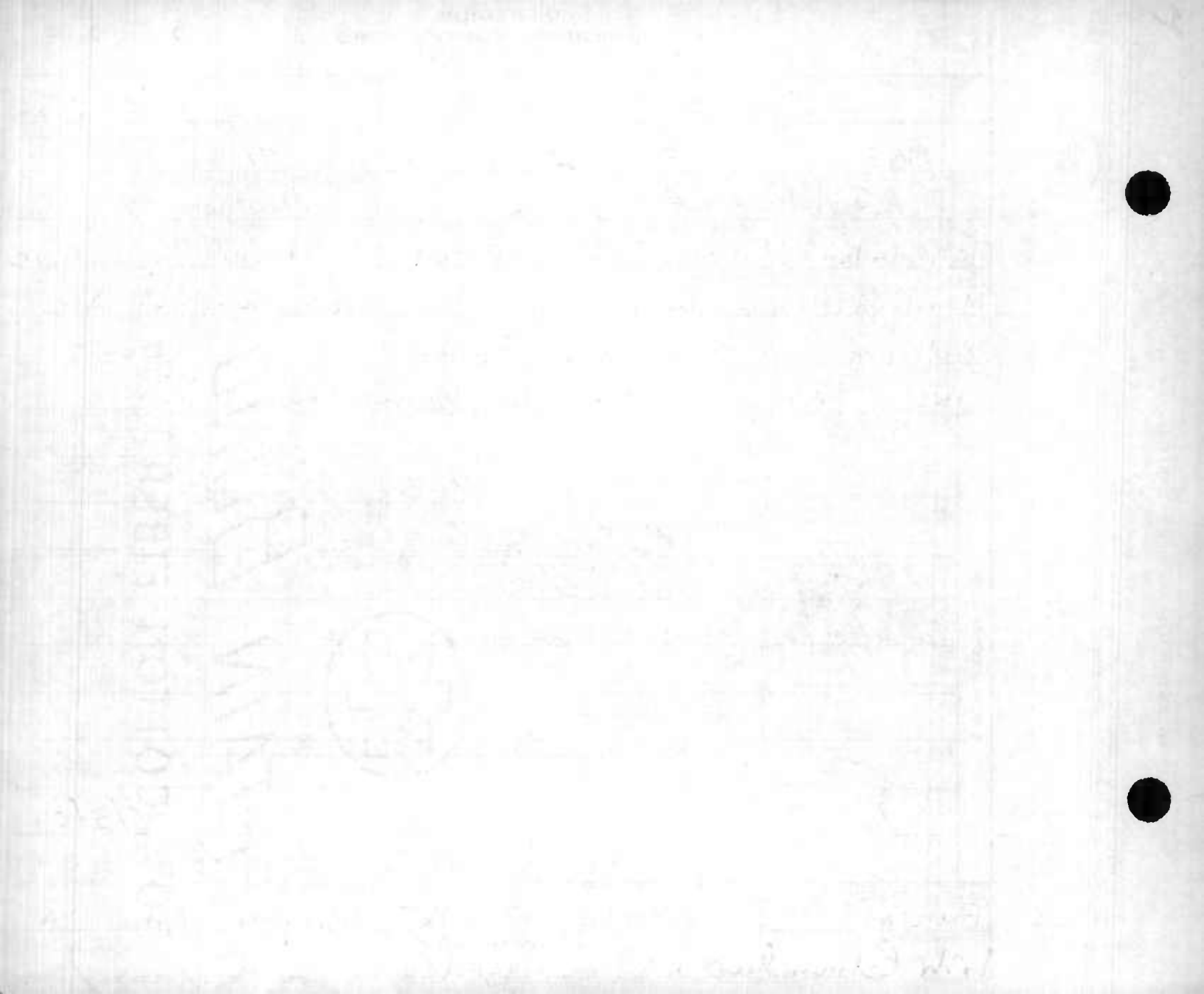
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1 - FOR STATE REGISTRAR					8 0 1 6 0 3 2					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
CLIFFORD Scott WENDELL					6 1 88 2:46 PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
MALE		WHITE		2 10 01		79 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
N.J.		USA				Montgomery MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK		Adventist Hospital				Manager		Automotive		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS			
Maryland MONTG					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		418 No Summit Ave			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
William S Wendell					Flora Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT			
Yes					W.W.I		577-10-0027 Mary Virginia Lewis			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4414 Massive Petechial Hemorrhage					15-30 min					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					DUE TO, OR AS A CONSEQUENCE OF (b)					
					Chronic Aortic Aneurysm 6 mo+					
					DUE TO, OR AS A CONSEQUENCE OF (c)					
					Atherosclerotic Heart + Pericarditis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Transitional Cell Carcinoma Bladder										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
Feb-Mar '80		Bladder Carcinoma			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from 5/30, 19 80, to 6/1, 19 80, that (1) (we) last saw the deceased alive on 6/1, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (do not) view the body after death.										
22b. SIGNATURE					DEGREE		22c. DATE SIGNED			
SK Potts MD							6/2/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
Douglas K. Potts MD					831 University Blvd E. Silver Spring					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		June 5 1980		Arlington Nat		Arlington ARL VA				
24. FUNERAL DIRECTOR NAME					ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. Chambers					8655 Georgia Ave		JUN 5 1980		[Signature]	

0702 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)				2b. DATE OF DEATH				2c. HOUR	
		Stanley E. WHITEHURST				June 22 1980				8:30P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. MONTH		7b. YEAR	
Male		Caucasian		April 2 1922		58					
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7d. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.				Montgomery				MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		National Naval Medical Center				U. S. Army					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Virginia				Chesapeake		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1025 Shore Road			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Roger Armistead Whitehurst				Lillian Deal							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
Yes		WWII, Korea		229 14 9145		Mrs. Mary B. Whitehurst		See item 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma											
2030 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from Apr. 30 19 80, to June 22 19 80, that (I) (we) last saw the deceased alive on June 22 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Marina Nikhi Vernalis								June 23, 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Marina Nikhi Vernalis, M. D.						National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY		STATE	
Burial		June 25, 1980		Woodlawn Mem. Gardens		Norfolk				Virginia	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Sturtevant Funeral Home		JUL 3 1980		William R. Sturtevant							
5201 Portsmouth Blvd.				Portsmouth, Virginia							

Virginia

June 26, 1903 Woodland, New, Virginia, Norfolk

Dear Sir,

Enclosed please find \$5.00 for the purchase of the
book "The History of the Commonwealth of Virginia"
by John Smith, published by the Virginia Historical Society,
Richmond, Virginia.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

1. RELEASED NAME (TYPE OR PRINT) **RAYMOND** **WHITMER**

2. SEX **Male**

3. RACE **Caucasian**

4. DATE OF BIRTH **12-31-71**

5. AGE (IN YEARS LAST BIRTHDAY) **88** YRS.

6. BALTIMORE CITY OR COUNTY OF DEATH **Montgomery** MD.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **VIRGINIA**

7b. CITIZEN OF WHAT COUNTRY? **U.S.**

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **SUPERVISOR RTD.**

10. CITY OR TOWN OF DEATH **Dithersa**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **Suburban Hosp.**

12. KIND OF BUSINESS OR INDUSTRY **SAFeway STORES**

13a. STATE **Maryland**

13b. COUNTY **Montgomery**

13c. CITY OR TOWN **BETHESDA**

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS **7802 RADNOR RD.**

14. FATHER'S NAME **JOHN** **H.** **WHITMER**

15. MOTHER'S MAIDEN NAME **ALICE** **THORNE**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **NO**

16b. SOCIAL SECURITY NO. **578-09-5233**

17. INFORMANT (Son) **WARREN L. WHITMER** ADDRESS **1020 MAPLE AVE. ROCKVILLE, MD.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **Septicemia, Irreversible** DUE TO, OR AS A CONSEQUENCE OF (b) **Inoperable osteomyelitis** DUE TO, OR AS A CONSEQUENCE OF (c) **7302**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **May 8** 19 **80**, to **June 13** 19 **80**, that (I) (we) last saw the deceased alive on **June 13** 19 **80**, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)

22b. SIGNATURE **James E. Wilson, Jr. M.D.** DEGREE **M.D.** ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED **6/13/80**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **James E. Wilson, Jr. M.D.**

22e. ADDRESS **11125 Rockville Pike, Rockville, Md. 20852**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **BURIAL**

23b. DATE **JUNE 16, 1980**

23c. NAME OF CEMETERY OR CREMATORY **PARKLAWN CEME.**

23d. LOCATION CITY OR TOWN COUNTY STATE **ROCKVILLE MONTG. MD.**

24. FUNERAL DIRECTOR NAME **JOSEPH CAWLER'S SONS INC.** ADDRESS **6130 WISC. AVE., N. W. WASH., D. C. 20018**

25a. DATE REC'D BY REGISTRAR **JUN 15 1980**

25b. REGISTRAR'S SIGNATURE **[Signature]**

16

XXC

(100)

100-1000

100

100-1000

100-1000

100-1000

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 6 0 3 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Kathryn I. Williams			2a DATE OF DEATH MONTH DAY YEAR 6/13/80			2b HOUR 6:53 PM				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Apr. 28 1890		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10 CITY OR TOWN OF DEATH Gaithersburg		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Asbury Methodist Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY own home		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Sil. Springs		13d INSIDE CITY LIMITS? NO		13e STREET ADDRESS 1905 Tilton Drive.	
14 FATHER'S NAME FIRST MIDDLE LAST George Grant Templin			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Liberty A. Knapp							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) none		17 INFORMANT (sister) ADDRESS Mrs. Cecil M. Roeder - (same as 13e)						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral insufficiency 4379 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - generalized (c) Old left sided cerebral vascular accident								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the decedent from 19 75 to present 19 80 , that (I) (we) last saw the decedent alive on Apr 13 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.										
22b SIGNATURE John B. Umhau MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 6/13/80		
22d PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umhau MD				22e ADDRESS 8805 Conn. Ave., Clarks - Md.						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6-16-80		23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.		23e DATE REC'D. BY REGISTRAR JUN 18 1980		
24 FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.										
25 REGISTRAR'S SIGNATURE James McBrady										

Chas E. Jones

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

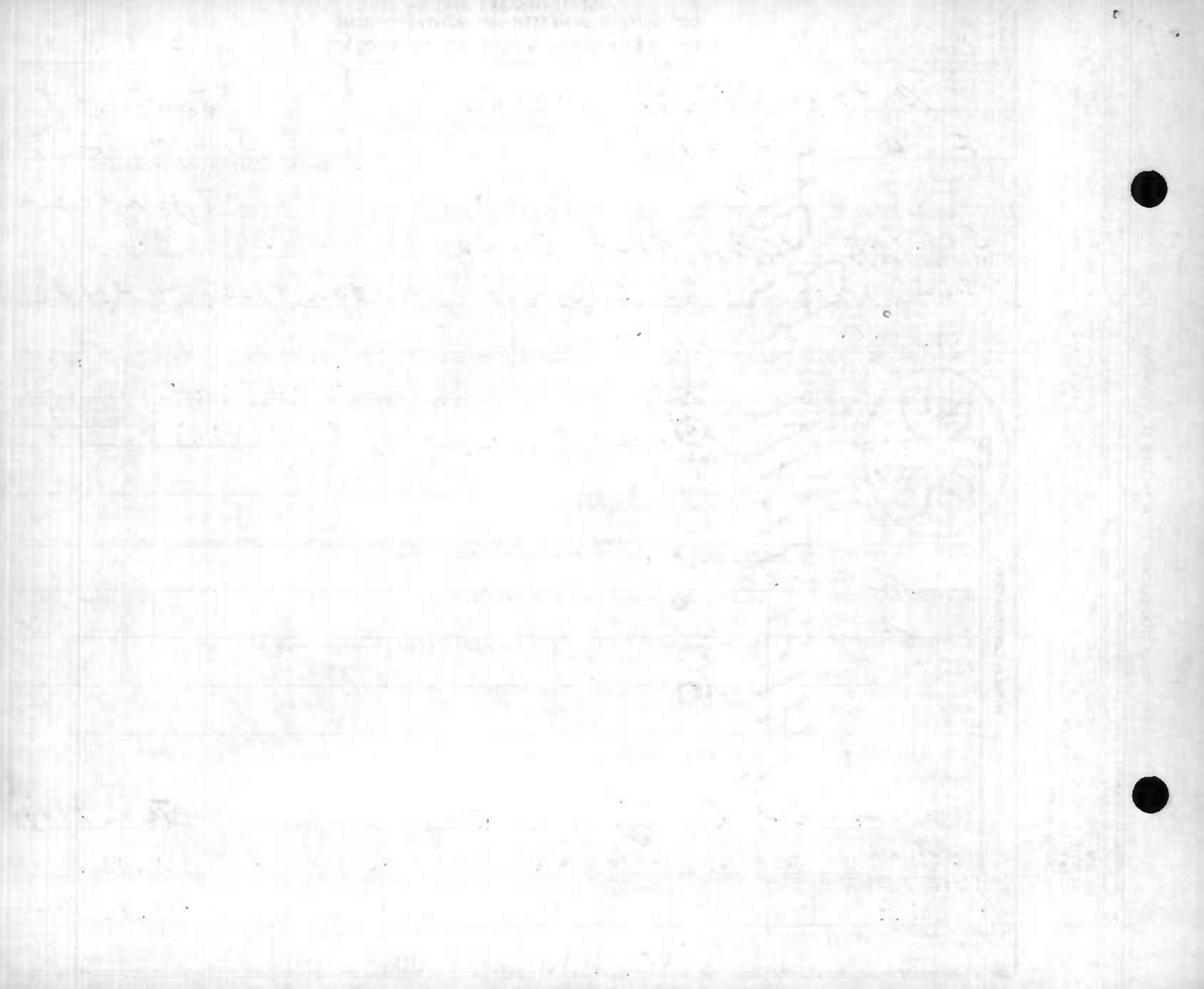
BP
DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

16036

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		21. HOUR	
Betty Allison		Wise						June 2		19		80						8 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		22. HOUR	
F	W	June 24 1900		79 YRS.						June 4		19		80				840 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Washington, DC		USA				Montgomery MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Sil. Spg.		18300 G/2dc Ct. Apt. 3c.		Housewife		own home													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		Mont.		Sil. Spg.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15300 G/2dc Ct. Apt 3c.											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (daughter)		ADDRESS									
Matthew (unknown)		Allison Bennett		no		217-80-7576		Betty J. D'Agostino-Massapegua, NY		4 Ensign Dr.,									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Dis</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u>																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED											
John S. Rogers, DME		1919 Seminary Rd., S.S. Md.						June 7, 1980											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Cremation		6-6-1980		Metropolitan Crematory		Alexandria Fairfax Va.													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Walter E. Pumphrey, Inc.,		8434 Ga. Ave., S.S. Md.		Mg Buchanan		JUN 10 1980													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
I. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST HILLIS KIMBRELL WILSON Hillis Kimbrell Wilson					MONTH DAY YEAR 6 25 80				
3 SEX					2b. HOUR				
Male					8 ⁰² AM				
4 RACE					5 DATE OF BIRTH				
White					MONTH DAY YEAR Jan. 11 1903				
6 AGE (IN YEARS LAST BIRTHDAY)					7a. CITIZEN OF WHAT COUNTRY?				
77 YRS.					U.S.A.				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
Missouri					9 BALTIMORE CITY OR COUNTY OF DEATH				
10 CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				
Gaithersburg					Asbury Village				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
Asst. Dir. Trans.					U.S. Gov't.				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. CITY OR TOWN				
13a. STATE					13b. CITY OR TOWN				
Md.					Mont. Bethesda				
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST James Norton Wilson					FIRST MIDDLE LAST Esther Ann Melson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
No					577-60-2025				
17 INFORMANT					ADDRESS				
Wife					Winifred Fairchild Wilson, Same as item 13.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Fatal arrhythmia</u>									
DUE TO OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>									
DUE TO OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Chronic Obstructive Pulmonary Disease</u>									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18/80</u> , 19 <u>80</u> , to <u>6/25/80</u> , 19 <u>80</u> , that (I) (we) (us) lost saw the deceased alive on <u>6/18/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					22b. SIGNATURE <u>Henry C. Serugo MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22c. DATE SIGNED <u>6/25/80</u>					22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HENRY C. SERUGO MD</u>				
22e. ADDRESS <u>5413 Cedar La. Bethesda Md.</u>					23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				
23b. DATE <u>6/27/1980</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland, Maryland.</u>					24 FUNERAL DIRECTOR NAME <u>Joseph G. Wler's Sons Inc.</u> ADDRESS <u>5130 Wisconsin Ave., N.W. Wash., D.C.</u>				
25a. DATE REC'D. BY REGISTRAR <u>JUN 27 1980</u>					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

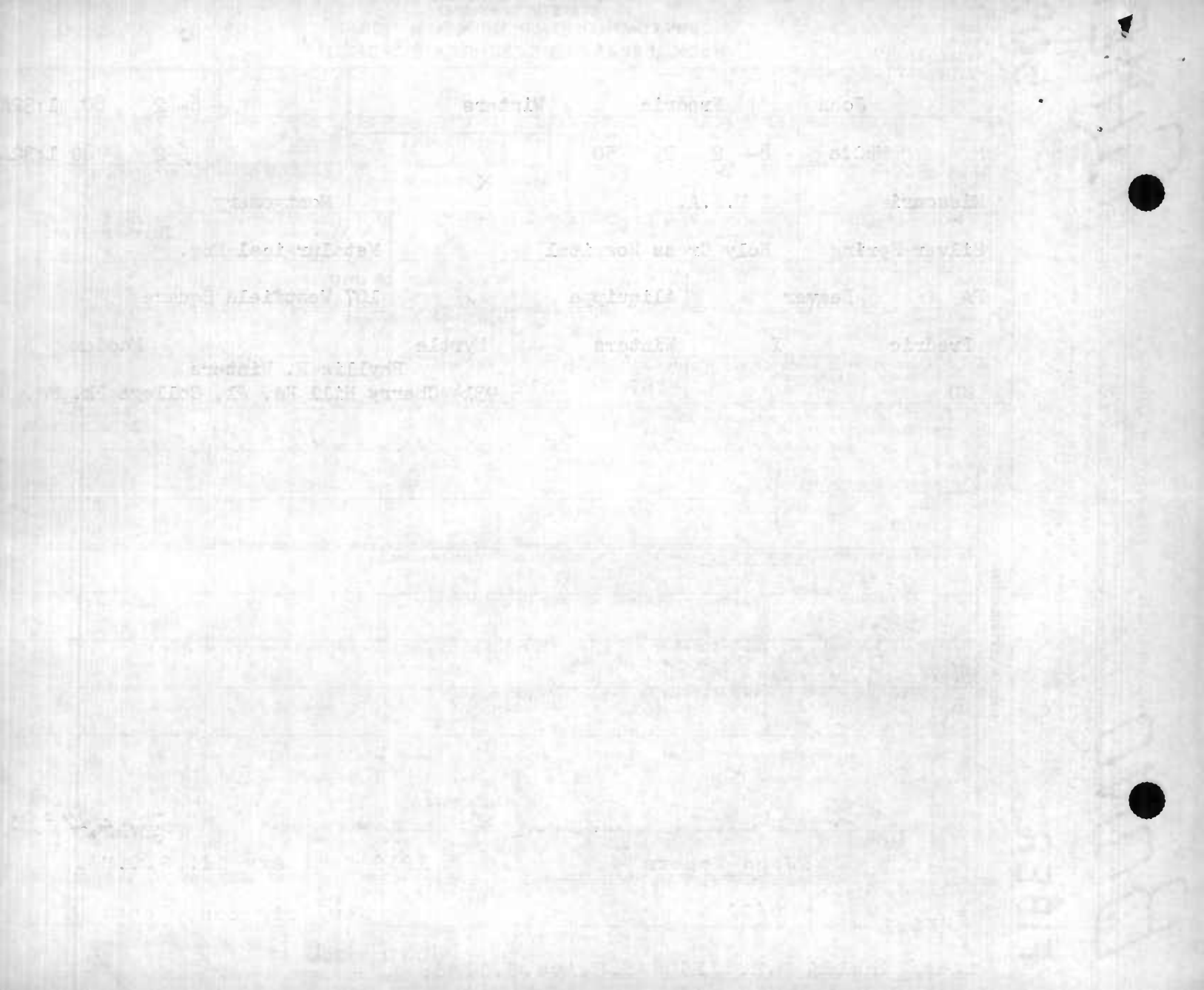
BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITALS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16038	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Fredric Winters										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 6-2 19 80	
3. SEX M 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 8-2-29 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 50 YRS.										2b. HOUR 1:32A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-2 19 80	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.										2d. HOUR 1:32A	
10. CITY OR TOWN OF DEATH Silver Spring 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Metalurgical Eng.										12b. KIND OF BUSINESS Bureau of Mines	
13a. STATE PA 13b. COUNTY Beaver 13c. CITY OR TOWN Aliquippa 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 107 Westfield Square	
14. FATHER'S NAME FIRST MIDDLE LAST Fredric I Winters 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Maddex											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO 16b. SOCIAL SECURITY NO. 487 30 2319 17. INFORMANT Phyllis R. Winters										17. ADDRESS 9314 Cherry Hill Rd., #1, College Pk., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>											
19a. DATE OF OPERATION <u>None</u> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>None</u> 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Rogers</u> M.D. TITLE (SPECIFY) MEDICAL EXAMINER										DATE June 11 1980	
EXAMINER'S NAME (TYPE OR PRINT) John Rogers ADDRESS 1919 Seminary Rd. S.S.Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 6/5/80 23c. NAME OF CEMETERY OR CREMATORY New Brighton, Penn.										23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi F.H. 11800 N.H. Ave. S.S.Md.										25a. DATE REC'D. BY REGISTRAR JUN 5 1980 25b. REGISTRAR'S SIGNATURE <u>John Rogers</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

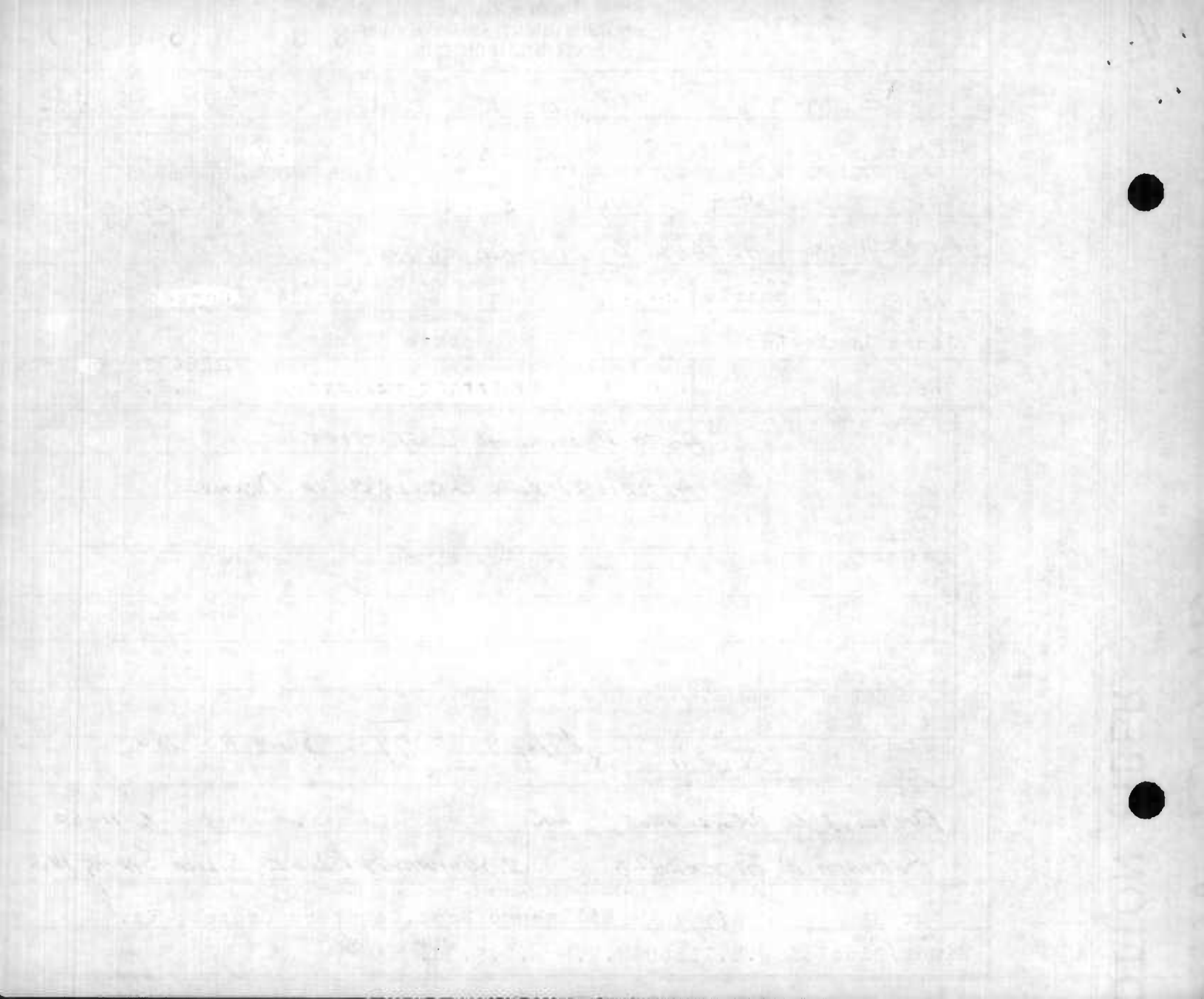
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

83 70 83 3 9 9 1

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 8016039						
1. DECEASED NAME (TYPE OR PRINT) ETHEL WOODSON			2a. DATE OF DEATH MONTH 6 DAY 11 YEAR 80			2b. HOUR 8:30 AM			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH 10 DAY 7 YEAR 1892		6 AGE (IN YEARS (LAST BIRTHDAY)) 87 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.			
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ALTHEA WOODLAND N.H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VA.		13b. COUNTY Albamarle		13c. CITY OR TOWN Crozet		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 245 Crozet, Va.	
14 FATHER'S NAME FIRST James MIDDLE Lewis LAST Rea			15 MOTHER'S MAIDEN NAME FIRST Bettie MIDDLE Black LAST 			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None			
16b. SOCIAL SECURITY NO. 230 20 0130D		17 INFORMANT Bettie Stanerson			ADDRESS 1204 Sarah Drive S.S.Md.				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MAY 9 19 79 to JUNE 11 19 80 , that (I) (we) last saw the deceased alive on JUNE 11 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bernard A. Fitzgerald				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD				22e. ADDRESS 217 UNIVERSITY BLVD E, SILVER SPRING MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/13/80		23c. NAME OF CEMETERY OR CREMATORY Hillsboro Bapt. Cemetery Crozet, Va.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME Hines/Rinaldi ADDRESS F.H.11800 N.H.Ave.S.S.Md.				25a. DATE REC'D. BY REGISTRAR JUN 17 1980		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP



FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16040			
1. DECEASED NAME (TYPE OR PRINT) George Davidson Wyatt										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6-19-1980										2b. HOUR 11:40 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 4 DAY 13 YEAR 1915		6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.		7. IF UNDER 1 YR. MONTHS 0 DAYS 0		8. IF UNDER 24 HRS. HOURS 0 MIN 0		2c. DATE PRONOUNCED DEAD June 19 1980										2d. HOUR 12:45 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD											
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Grounds of Woodmont Country Club										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Groundskeeper				12b. KIND OF BUSINESS OR INDUSTRY Country Club					
13a. STATE Maryland										13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1201 Rockville Pike							
14. FATHER'S NAME FIRST Luther MIDDLE Gratten LAST Wyatt										15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE L. LAST Creger													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 228 14 8475				17. INFORMANT Blanche H. Wyatt ADDRESS same as 13e															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute 411 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED June 19 1980											
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS Old Georgetown Rd. Bethesda, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/23/80		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park				23d. LOCATION CITY OR TOWN Rockville, Maryland COUNTY STATE													
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Maryland										25a. DATE REC'D. BY REGISTRAR JUN 23 1980				25b. REGISTRAR'S SIGNATURE [Signature]									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DULY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16041
1- STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR
John Harvey Wyatt						ESTIMATED <input checked="" type="checkbox"/> 6 20 80				M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE IN YEARS	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
male	white	MONTH DAY YEAR		LAST BIRTHDAY	MONTHS	DAYS	HOURS	MIN	MONTH DAY YEAR	
		Nov. 4 1906		73					6 23 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
S. Carolina		USA					Montgomery County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda		Suburban Hospital				Retired		Vending Machine Co.		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland		Montgomery		Sil. Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1400 Fenwick Lane,		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST				FIRST MIDDLE LAST						
James F. Wyatt				Aleen Moore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (niece) 5428 Sargent Road, Debra Twigg-Chillum, Md.						
no		none		577-10-1476						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Gun shot wound of head Gun: hand gun										
DUE TO, OR AS A CONSEQUENCE OF										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? (HO)		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
				HOUR A.M. MONTH DAY YEAR		found shot				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION				
				bedroom		1400 Fenwick Lane, Silver Springs, Mont Co. MD				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED		
J. S. Shaw				Assistant				6/24/80		
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS						
Hormez R. Guard, M.D.				111 Penn Street, Balto., MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE		
Burial		6-28-80		Woodlawn Cemetery		Greenville		S. Carolina		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
Warner E. Pumphrey, Inc., 8434 Ga. Ave., S.S. Md.				JUN 27 1980				Dorothy McBratney		

STANDARD EXHIBIT - 2 (SEE INSTRUCTIONS)

NAME	ADDRESS	CITY	STATE	ZIP
J. Edgar Hoover	Washington, D.C.	Washington	D.C.	20535
Richard M. Nixon	Washington, D.C.	Washington	D.C.	20503
Spiro T. Agnew	Annapolis, Md.	Annapolis	Md.	21403
Hubert H. Humphrey	Minneapolis, Minn.	Minneapolis	Minn.	55403
Lyndon B. Johnson	Austin, Tex.	Austin	Tex.	78701
Walter F. Mondale	St. Paul, Minn.	St. Paul	Minn.	55101

On this date, we have:

1. Received from the above named person or persons, a sum of \$100.00, for the purpose of the purchase of a new car.

2. Received from the above named person or persons, a sum of \$50.00, for the purpose of the purchase of a new car.

3. Received from the above named person or persons, a sum of \$25.00, for the purpose of the purchase of a new car.

4. Received from the above named person or persons, a sum of \$12.50, for the purpose of the purchase of a new car.

5. Received from the above named person or persons, a sum of \$6.25, for the purpose of the purchase of a new car.

6. Received from the above named person or persons, a sum of \$3.12, for the purpose of the purchase of a new car.

7. Received from the above named person or persons, a sum of \$1.56, for the purpose of the purchase of a new car.

8. Received from the above named person or persons, a sum of \$0.78, for the purpose of the purchase of a new car.

9. Received from the above named person or persons, a sum of \$0.39, for the purpose of the purchase of a new car.

10. Received from the above named person or persons, a sum of \$0.19, for the purpose of the purchase of a new car.

Witness my hand and seal this 1st day of January, 1964.

J. Edgar Hoover
Director

Richard M. Nixon
Vice President

Spiro T. Agnew
Governor

Hubert H. Humphrey
Senator

Lyndon B. Johnson
President

Walter F. Mondale
Senator

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
Irene (NMN) Yaskovich		2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		Jan. 6, 1927	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Pa.		U S A		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Silver Spring		1817 Arcola Avenue		Housewife	
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	
Md.		Montgomery		Silver Spring	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. SOCIAL SECURITY NO.	
John Komichak		Rose Kostiuik		188-20-4763	
16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
No		Harold Yaskovich		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
				PART I DEATH WAS CAUSED BY:	
				IMMEDIATE CAUSE (a) Gunshot Wound of Thorax	
				DUE TO, OR AS A CONSEQUENCE OF	
				(b)	
				DUE TO, OR AS A CONSEQUENCE OF	
				(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		11:30 P.M. 6 5 1980		Subject found shot	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		home		1817 Arcola Ave., Silver Spring, Montgomery, MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon, M.D.		Assistant		6/6/80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY	
Burial		June 10, 1980		Arlington National	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D BY REGISTRAR	
Warner E. Pumphrey		8434 Ga. Ave.		JUN 13 1980	
		Silver Spring, Md.		5b. REGISTRAR'S SIGNATURE	

BP

Received

25

1900

Amount \$100.00

For balance

John Smith

100.00

100.00

100.00

100.00

100.00